ADVANTAGE

...rising above the service you expect

BENEFITS - AT - A GLANCE

Unless otherwise noted, all services must be provided, authorized or referred by the Member's Primary Care Physician.
Policy maximum is $2,000,000 per covered person.

BENEFITS are subject to an individual deductible of $2,000 ($4,000 family) with the exception of physician office services which have copays only.
After the deductible, benefits are payable at 80% and 50% of allowable charges (unless otherwise stated) and are subject to an individual out-of-pocket maximum of $4,000 ($8,000) per family per contract year, not including the deductible. Total member responsibility including deductible and out-of-pocket max is $6,000 per individual ($12,000 per family). Note: Vision, maternity office visits, and Rx copays are not subject to deductible.

PHYSICIAN SERVICES	COPAY
Office Visits for Illness or Injuries	
* Primary Care Physician Office Visit	**$20 Copay per PCP visit**
* Specialty & referral Physician Office Visit	**$40 Copay per SCP visit**
Non-Office Visits	
* Physician visits in the hospital	**20% Coinsurance**
* Physician visits in the home	**20% Coinsurance**
The following services have a copayment/ coinsurance based upon location of service:	
* Professional services related to a surgical procedure	
* Physician services for visit examinations when confinement in a Hospital or Skilled Nursing Facility	
* Radiology, laboratory, EKG, EEG, and sigmoidscopy	
Physician Services for Wellness & Preventive	**Included in the physician office visit Copay.**
* Routine Physical Exam	
* Routine Blood Cholesterol Screening	
* Colorectal Cancer Screening	
* Routine Gynecological Services	
* Routine Mammographies	
* Routine Prostate Specific Antigen (PSA)	
* Routine Immunizations	
* Hearing Tests	
* Vision Services	

OTHER SERVICES	COPAY/COINS.
Allergy Serum	**50% Coinsurance**
Dental - Injury to Sound & Natural Teeth	**$40 Copay**
Dialysis	**20% Coinsurance**
Family Planning Services to include sterilization and contraceptive devices.	**50% Coinsurance up to $2,500 lifetime max.**
Home Health Services	**20% Coinsurance**
Infertility Diagnostic Testing	**$40 Copay**
Injections (Therapeutic) and Infusion Therapy	**$0 Copay**
Maternity Care - Professional obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including physician services, laboratory and x-ray services as medically necessary and appropriate. Inpatient hospital admissions related to pregnancy and/or birth are covered as any other inpatient hospital facility admission.	**$200 Copay for PCP $400 Copay for SCP**
Non-surgical Treatment of Morbid Obesity (In-network physician supervised weight loss treatment program) Max of 6 visits per calendar year.	**Enrollment fees in excess of $50 after $40 copay per visit.**
DME, Artificial Aids, & Corrective Appliances	**50% Coinsurance**
Short-term Therapies: Cardiac Rehabilitation, Physical, Speech, Occupational Therapy, Pulmonary Rehabilitation (Limited to a combined 60 visits per each distinct condition or episode or as authorized through a medical management regimen)	**20% Coinsurance**
Skilled Nursing Facility: (Limited to 100 days per Medicare guidelines)	**20% Coinsurance**

OTHER SERVICES CONT.	COPAY/COINS.
Vision Services: Routine Annual Eye Exam (Discount on frames and eyeglass lenses when purchased through participating VSP providers)	**$15 Copay per exam**

BEHAVIORAL HEALTH SERVICES	COPAY/COINS.
Mental Health Inpatient Services	**20% Coinsurance**
Mental Health Outpatient Services	**$40 Copay per visit**
Substance Abuse Inpatient Services (Detoxification: two admissions per lifetime)	**20% Coinsurance up to 14 days per calendar year**
Substance Abuse Outpatient Services	**20% Coinsurance up to 20 visits per calendar year**
Pervasive Developmental Disorder (PDD)	**Included in the office visit copay**

INPATIENT HOSPITAL SERVICES	COPAY/COINS.
Semi-Private room and board, Private room if medically necessary Services include:	**20% Coinsurance**
* Operating, recovery room and other special units including intensive care	
* Maternity care	
* Hospital, ancillary services including lab, x-ray, EKG and other diagnostic services	
* Anesthesia, physical therapy and medications	
* Administration of blood and blood plasma	
* Physician and Specialist services	

OUTPATIENT SURGERY SERVICES	COPAY/COINS.
Outpatient surgical services (Outpatient surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia.)	**20% Coinsurance**

OUTPATIENT SERVICES	COPAY/COINS.
Outpatient services (Including but not limited to: laboratory, pathology, radiology, electrocardiology (EKG) & electroencephalography (EEG)	**$0 Copay**
MRI, CT, MRA, PET & SPECT scan	**$0 Copay**

EMERGENCY SERVICES	COPAY/COINS.
Emergency Room	**20% Coinsurance**
Emergency Ambulance Services	**20% Coinsurance**
Urgent Care Facility Services	**20% Coinsurance**

PRESCRIPTION BENEFITS	COPAY/COINS.	
	Retail	**Mail-Order**
	$250 RX Deductible	
Generic - Formulary*	**$15 Copay**	**$30 Copay**
Brand Name - Formulary*	**$30 Copay**	**$60 Copay**
Non- Formulary*	**50% coins.**	**50% coins.**
(Calendar maximum benefit of $3,000)		

The copay that you will pay is per prescription dispensed up to a 30-day supply for retail and up to a 90-day supply for mail-order Step Therapy Program; * Mandatory formulary generic when available or member pays difference.

Biopharmaceutical Drugs ($10,000 annual maximum benefit)	**50% Coinsurance**
Diabetes Supplies (Includes glucometer, lancets, and test strips)	**50% Coinsurance**

NON-COVERED SERVICES

- Services and supplies that are not performed, arranged, authorized, or approved in advance by the Member's PCP, except in an emergency situation as stated in your certificate
- Services and supplies that are not medically necessary
- Items or devices primarily used for comfort
- Non-skilled care, rest cures, respite care, convalescent care or domiciliary care, regardless of the setting
- Physical exams and related expenses when provided for employment, school, travel, immigration, or insurance purposes (related x-rays and lab expenses)
- Orthodontia and other dental services except as expressly stated in the Certificate of Coverage
- Eyeglass lenses unless medically necessary following cataract surgery; refractive surgery performed to treat myopia or hyperopia; refractions
- Cosmetic or reconstructive procedures and any related services or supplies unless deemed medically necessary
- Except for physician-supervised weight loss treatment programs authorized by ADVANTAGE, services, drugs and supplies for weight loss, diet, health or exercise programs, health club dues, or weight reduction clinics. However, Member is entitled to access ADVANTAGE's discount for such drugs through a Participating Pharmacy
- All treatment, procedures, facilities, equipment, drugs, devices, services or supplies that are considered to be investigational/experimental
- Voluntary termination of pregnancy, except when the life of the mother would be endangered if the fetus were carried to term
- Treatment of temporomandibular joint (TMJ) disorder
- Treatment of infertility, including drugs
- Hearing aids
- Growth Hormones
- Over-the-counter drugs
- Birth control drugs or devices that do not require a prescription
- Surgical treatment of Morbid Obesity
- Other exclusions as described in the Certificate of Coverage

LIMITATIONS

- Short-term therapies are limited to conditions the physician feels are subject to continuing improvement with treatment over a two-month period.
- Members must use the Plan's participating providers. These providers are subject to change from time to time.
- Members must live or work within the Plan's service area to remain covered by the Plan.
- Members must select a PCP within a 30-mile radius of their residence or place of work
- Mandatory Generic Substitution is required for all prescription drugs. When the Member or the Member's physician requests a Brand Name prescription drug and a Generic equivalent is available, the Member will pay his/her applicable Copayment plus the cost difference between the Generic and the Brand Name Drug.

If you have any questions please contact ADVANTAGE Health Solutions, Inc. at:
P.O. Box 80069
Indianapolis, IN 46280
(317) 573-6228 or (800) 553-8933, 7:30 a.m. - 5:30 p.m. (Monday - Friday)
TDD: 800-743-3333 (hearing impaired)

VISIT OUR WEBSITE AT
www.advantageplan.com

THIS SUMMARY IS A GENERAL OUTLINE OF COVERED BENEFITS UNDER YOUR PLAN AND DOES NOT INCLUDE ALL THE BENEFITS, LIMITATIONS AND NON-COVERED SERVICES OF THE CERTIFICATE OF COVERAGE. PLEASE SEE THE CERTIFICATE OF COVERAGE FOR SPECIFIC DETAILS. YOU MAY REQUEST A COPY OF THE CERTIFICATE OF COVERAGE BY CALLING (800) 553-8933 or email

December 19, 2006 - December 19, 2009